Ayushman Bharat Initiative (2018): What we Stand to Gain or Lose!

Introduction

"Right to health" is central to exercise the basic human rights. However, our constitution is yet to recognize health as a fundamental right. Various articles and several judgments by honorable supreme court make enough provisions for "access to health" to the citizens under directive principles but is short of its inclusion as a fundamental right including the right to seek constitutional remedy if health/care is denied.[1]

Since the submission of Bhore Committee report (1946), efforts are made by central/state governments to provide health care through countrywide network of three tier health-care institutions and various national health programs. Success stories of eradication of smallpox, dracunculiasis, regional elimination of leprosy, neonatal tetanus, controlling diseases such as malaria/other vector-borne diseases, and reduction in maternal/infant mortality are few of its achievements. However, the system has failed to provide quality curative and rehabilitative care to the masses, especially in remote areas leading to inequality and inequity in access of health care. In India, around 6% do not seek health care due to financial reasons,[2] and among those who do, experiences are often financially catastrophic and impoverishing. Household out-of-pocket expenditure (OOPE) in India is 67% of total health expenditure,[3] 12th highest among 191 nations[4] and 6th highest among 50 low-middle income nations.[5]

It would not be misleading to say that health has been a neglected issue in the governance. It has never been a priority with any political party and is usually a last-minute casual inclusion in the election manifestos. Therefore, it is good to see some positive steps being taken in the recent times to address this issue–National Health Policy (NHP) 2017 and Ayushman Bharat initiative, both of which are critical to attain the Universal Health Coverage (UHC) – also the theme of world health day 2018 and Sustainable Development Goals (SDGs) - to which India is a signatory and stands committed to achieve.

What is Ayushman Bharat?

In the budget speech of 2018, the Ayushman Bharat for a new India 2022 was announced which included two major initiatives, namely creation of health and wellness centers (HWCs) and an ambitious National Health Protection Scheme (NHPS).[6]

Health and wellness centers scheme

Here, a larger and comprehensive package of primary health care will be delivered at the grass root level by upgrading subcenters (SCs) to HWCs. Focus has now been broadened from preventive to promotive, curative and palliative care. Upgraded SC or the HWC will have point of care, wellness room for yoga, physiotherapy and group meetings, consultation space with full privacy, free diagnostics and pharmacy, facilities for telemedicine and waiting area for 30 plus persons. Package of services at HWC is also ambitious and includes common ophthalmic and ENT problems, oral health, mental health ailments, elderly and palliative health, emergency medical services, management of communicable and noncommunicable diseases and general outpatient care; besides the reproductive, maternal, neonatal, child, and adolescent health services. It also includes creation of electronic health records with the support of a robust IT system. Although not mentioned, it is implied that these HWCs will continue to play their current roles in all national health programs including malnutrition correction (all micronutrient/macronutrient deficiency) and vaccination. Currently, SCs are staffed with one male and female health workers but HWCs will require other dedicated medical-paramedical staff. HWC will thus require reorientation of staffing and infrastructure. The scheme, aiming to upgrade all SCs across the country, was launched by Hon. Prime Minister on April 14, 2018 in Odisha.

Ayushman Bharat National Health Protection Scheme

This centrally sponsored flagship scheme aims to provide an annual health cover of up to Rs. 5 lakh to vulnerable 10 crore families (approximately 50 crore persons – 40% of country's population) based on Socio Economic and Caste Census database. Scheme will provide a cashless cover for identified secondary/tertiary treatments, in public/empaneled private facilities without any cap on family size and age. All preexisting conditions will be covered from day one of the policy. The benefit cover will also include pre- and posthospitalization expenses as well as transport allowance.[7]

This scheme is also being implemented from the current year, and as part of demand generation, a massive drive has been launched which includes health education campaigns, community mobilization and identification/information collection of the beneficiaries through Gram Sabhas. This year, April 30 is being observed as Ayushman Bharat Divas when every rural beneficiary will not only be informed/explained about the scheme but data (mobile number, ration card details, change in family status, etc.) will be recorded for each eligible beneficiary. Each one of them will be linked with a HWC to ensure that no one is deprived of the scheme benefits.

NHPS will subsume the ongoing centrally sponsored schemes such as Rashtriya Swasthya Bima Yojana (RSBY) and the

Senior Citizen Health Insurance Scheme. Dubbed as Modicare, the scheme would be the largest state-funded health insurance scheme and a massive leap forward toward UHC, by decreasing OOPE and protecting around 40% vulnerable population from catastrophic health-care expenditure.[7]

Critical Areas Under Health and Wellness Center Scheme

1. Budget allocated under HWC scheme is Rs. 1200 crores for upgradation of 1,50,000 SC.[6] It works out to be Rs. 80,000 per SC for the year. Hoping its a recurring grant, it is still grossly insufficient to meet the logistics, human resources, and overhaul required to meet the expanded range of services. It needs to be noted that over 25% of the functioning SCs require buildings to be constructed.[8] Deputing staff and lending existing infrastructure will only worsen the situation. This gap between policy intention and fund allocation needs to be addressed.
2. It must also be realized that adding more and more services to grass root/lower centers can prove detrimental because then they will underserve their primary objectives (promotive and preventive) and ineffectively subserve the added responsibilities.
3. The services envisaged under HWC are, in fact, not even available at most of the community health centers (CHCs). In view of huge shortage of specialist doctors and other support at CHCs [Table 1],[8] upgrading SCs to HWCs without matching referral setup can be counterproductive.

Critical Areas Under Ayushman Bharat National Health Protection Scheme

1. NHP 2017 aims to ensure UHC and reinforce the trust in public health-care system by strengthening and expanding the services. It aims to increase governmental health expenditure as percentage of gross domestic product from current 1.15% to 2.5% by 2025.[9] This means almost doubling the budgetary allocation in the next 6–7 years. It seems impossible, considering that 2018–2019 budgetary allocation (Rs. 52,800 crores) is only 2.4% higher over the last year.[10] Actually, if adjusted for inflation (4% last year), it is a cutdown in the allocation. Furthermore, with its endorsement of the SDGs, India will have to constantly raise its ambition (and expenditure) during the dozen years to the deadline by raising not just core budgetary spending every year, but also toward social determinants of health (affordable housing, planned urban development, pollution control, road safety, etc.). Unfortunately, governments are paying little attention to these issues, as the quality of life erodes even with steady economic growth.
2. In the current scenario, the annual premium of AB NHPS would be around Rs. 2000 per family to start with and would entail an expenditure of Rs. 20,000 crores (@ Rs. 2000 per family for 10 crore family).[11] Yet, another estimate from Niti Aayog puts this annual requirement at Rs. 10,000 crores.[12] This is in contrast to a similar Rashtriya Swasthya Suraksha Yojna proposed in Budget 2016 with an allocation of Rs 1,500 crore, to provide an annual cover of Rs. 1 lakh per economically weaker household.[13,14] However, this never saw light of the day. AB-NHPS, with five times the cover and higher number of beneficiaries, has been rolled out with allocation of Rs. 2,000 crores only. This gap is proposed to be bridged by matching contribution from the state governments. Please note that this premium is sure to go up to Rs. 5,000 or more in future; depending on the maturity of the scheme and pay outs in the long run.
3. The scheme is based on the concept of cooperative federalism. It will therefore be a challenge to achieve the desired goals unless all the different states agree to implement the scheme. The state's contribution to this is expected to be around 40% i.e. over Rs. 4,000 crores (considering the conservative Niti Ayog estimate). Will the states, already in a fiscal noose, be ready to dole out the amount? The situation will be complicated as many states are currently implementing their own health insurance schemes which will need to be harmonized, besides the socio political conflicts.
4. Single most important reason for nonavailability of health services (especially curative) in remote areas is the shortage of workforce at different levels. Situational analysis of the existing rural health care reveals that the health infrastructure shortfalls increase with increase in level of care. All India shortfall for rural public health facilities, calculated using the prescribed norms on the basis of rural population (from Census 2011), is 19% for SCs; 22% for primary health centers (PHC), and 30% for CHCs.[8] This shortfall is compounded by the shocking shortage for specialist doctors (around 80%) – essential for secondary/tertiary care [Table 1]. Failure of government-run rural health care system in providing

Table 1: Manpower status at primary health centers and community health centers in India in 2016-17

Indicator	*n*	Shortfall/vacant posts (%)
PHCs with		
One or nil medical officers	25354	16681 (65.8)
Nil laboratory technician	25354	9037 (35.7)
Nil pharmacist	25354	4730 (18.7)
Nil LMO	25354	6835 (27.0)
Blocks with no (BEEs)	5231	2027 (38.8)
CHCs with nil		
Surgeon	5510	4626 (84.0)
Gynecologist	5510	4225 (76.7)
Physician	5510	4585 (83.2)
Pediatrician	5510	4416 (80.2)

Source: Rural Health Statistics, 2017. PHCs: Primary Health Centers, LMO: Lady medical officer, BEEs: Block extension educators, CHCs: Community Health Centers

curative care results in the crowding of sick persons at urban facilities (mostly private sector) and increase in the OOPE (travel, stay, and loss of wages). NHPS, in the current format, focuses on secondary and tertiary care services which are concentrated in urban and unavailable in rural areas. Hence, it will not be able to check the movement of patients from rural areas to urban centers and thus may not make a significant dent to the OOPE.

5. Lack of utilization of public health facilities, consumer preference for private health care (65% of inpatients opt for treatment from private providers) and asymmetry of infrastructure and human resources (55% of beds in public hospitals with 80% of human resources in private sector) necessitates public–private partnership to deliver the UHC agenda.[15] Unable to provide stronger public health infrastructure and due to the failure of supply side health financing model in reducing OOPE; Government of India decided to experiment with demand side financing approach through the Public Health Insurance scheme - RSBY.[16] Stake holders in RSBY, and now NHPS, are: (a) Governmental (national/state) funding agency, (b) Government-run health system, (c) Private providers (Nursing homes/corporate hospitals), (d) Insurance companies and (e) End users or eligible beneficiaries. Please note that (c) and (d) are the commercial for profit organizations and except for occasional corporate social responsibilities, will get involved only if it is value accretive and there is financial viability/sustainability. Closer look into the empanelment of RSBY health-care providers reveals that in states with >1000 empanelled centers, public to private hospital ratio is 35:65.[16] This showcases the paradigm shift in role of government form health provider to health financer/purchaser. Studies also reveal that in absence of protocols, overmedication (drugs/surgeries/hospital stay) and abuse of the subsidies from governments do occur.[17]
6. NHPS is upgraded RSBY - wider services to be made available to a sizeable population. Considering the enormous potential and costs involved, it would be prudent to rigorously study the impact and effectiveness of RSBY, before scaling up the intervention. Several studies have found RSBY to be ineffective in reducing the burden of OOPE or providing significant financial protection for poor households.[18-20] Some of the reasons of why the eligible RSBY beneficiaries still spend on the health care are low enrollment (of 59 million eligible households, only 61% covered), inadequate insurance covers, and no coverage for outpatient costs.[18,20] Cost of outpatient treatment (preferred over hospitalization) can contribute to over 65% of OOPE,[20,21] but the same is not covered, even by the proposed NHPS. This is also a reason for a probable 23% increase in outpatient costs in the households enrolled under RSBY.[18] Furthermore, while hospitalization cost has gone up >10% between 2004 and 2014, RSBY's insurance coverage has remained unchanged.

Summary Points

1. As community medicine specialists, we would say that NHPS, to begin with, is a misnomer. It will not provide health care but only medical care and that too in patient care largely at private/corporate hospitals. It will not have the desired impact on already very high household OOPE unless the government-run system is strengthened.
2. Allocations for both NHPS and HWC schemes are not adequate, and if the failures documented for RSBY are any indication, the NHPS is likely to result in over-treatment or unnecessary surgeries.[20] Hence, if the scheme is used (misused/overused/abused), premium rates are sure to increase. Well-designed standardized protocols and guidelines for admission, testing, treatment, referral, recording, and good quality check system will be essential to ensure the success of this scheme. Determination/rationalization of reimbursement rates and their timely revisions, criteria for empanelment, postenrollment quality checks, optimal payment models, use of technology, enabling transparent governance, and effective redressal mechanisms will be required to ensure quality care, honest and better participation of the private sector.
3. Success of the scheme will depend upon focusing on health and not merely sickness. Reducing disease burden through robust primary care, focus on allied determinants of health, quality outdoor and indoor services in public hospitals and incorporation of indigenous school of medicine and technology will all help in checking farcical and wasteful expenditure. Instead of shrinking its role in health-care provision, participation of government system has to be increased progressively. If only some of these funds are allocated to revive/strengthen the system, patients will avail comprehensive health care nearer to their homes rather than being referred to far away urban private operators for on-demand secondary/tertiary care with added cost of transport, stay/loss of wages of attendant(s), etc. More allocation of funds and its innovative application to recruit and retain the specialists in government setup is the need of time. A study published recently has enumerated few such measures in this regard.[22]

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